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Revised on 8/19/2014

Submit

STARTING POINT
Child Care Resource and Referral
Family Child Care Home Update Form

Provider: _____
(First Name) *(Last Name)*

Address: _____

City: _____ **Zip:** _____ **County:** _____

Mailing Address: _____

City: _____ **Zip:** _____ **County:** _____

Primary Phone: ( ) _____ **ext.** _____ **Secondary Phone:** ( ) _____ **ext.** _____

Fax #: ( ) _____ **E-Mail Address:** _____

Website: _____

Update Method: ☐ **Phone** ☐ **Fax** ☐ **Postal Mail** ☐ **E-Mail**

Accepted Age Range:
From: ☐ **Years** ☐ **Months** ☐ **Weeks**
To: ☐ **Years** ☐ **Months** ☐ **Weeks**

Transportation:
☐ To/From Home ☐ To/From School
☐ Walking Distance to School ☐ Near Public Transportation

Which Age Groups Do You Transport?
☐ Infants (Newborns-18mos) ☐ Toddlers (18mos-36mos)
☐ Preschoolers(3yrs-5yrs not in Kindergarten) ☐ School-Agers (5yrs in Kindergarten-14yrs)

Family Child Care Setting:
☐ House ☐ Townhouse ☐ Duplex
☐ Apartment ☐ Mobile Home

Languages:
☐ English ☐ Spanish ☐ Asian ☐ American Sign Language
☐ Hebrew ☐ Russian ☐ Arabic ☐ Other: _____

Accreditation/ Education:
☐ High School ☐ Workshops/Trainings ☐ CDA ☐ NAFCC
☐ Associates Degree (Child Related) ☐ Associtaes Degree (Other)
☐ Bachelors Degree (Child Related) ☐ Bachelors Degree (Other)
☐ Masters Degree (Child Related) ☐ Masters Degree (Other)

Policies:
☐ Child Must Be Toilet Trained ☐ Written Contract ☐ Interview Required
☐ Written Polices ☐ Has Back-up Provider ☐ Provide Sick Child Care

****Required Fields, Please Fill Out Completely**

Days	Start Time	End Time
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		
☐ Sunday		

Accepts Children

☐ Full-Time ☐ Part-Time ☐ Both

Year Schedule

☐ Full Year ☐ School Year ☐ Summer Only

☐ Drop In ☐ Temp/Emergency Care

☐ Before School ☐ After School

☐ Rotating Schedule ☐ 24-Hour ☐ Open Holidays

Scheduling Flexibility Comments: _____

****Rates: (**Required Fields, Please Fill Out Completely)**

Age Groups	Weekly Full-Time	Daily Full-Time	Weekly Part-Time	Daily Part-Time	Hourly
Infant					
Toddler					
Preschool					

Special Rates:	Before School	After School	Before and After Full-Time	Summer/Break
School Age				

Additional Fees: ☐ Registration/Application Fee ☐ Deposit

Comments: _____

Financial Assistance: ☐ Publicly Funded Child Care ☐ Sliding Fee Scale ☐ Multi-child Discount

****Capacity By Age Groups: (**Required Fields, Please Fill Out Completely)**

1st Shift	Number Enrolled	Vacancies
Infant		
Toddler		
Preschool		
School Age		

2nd Shift	Number Enrolled	Vacancies
Infant		
Toddler		
Preschool		
School Age		

3rd Shift	Number Enrolled	Vacancies
Infant		
Toddler		
Preschool		
School Age		

****Required Fields, Please Fill Out Completely**

Special Needs: Number of children with special needs you are willing to serve? ☐

Number of children with special needs currently being served? ☐

Please list the specific special needs of children. For each of the following, list how many children have a specific need. (I.e. Asthma 3, Autism 4, etc.)

☐ Asthma ☐ Autism ☐ Cerebral Palsy
☐ Communications ☐ Downs Syndrome ☐ Emotional/Behavioral
☐ Epilepsy/Seizures ☐ Hearing/Speech ☐ MR/DD
☐ Physical Mobility ☐ Spina Bifida ☐ Vision Impaired
☐ Other (List in comments, please be specific):

Comments: _____

_____

_____

_____

Special Needs Training/Experience:
☐ Emotional/Behavioral ☐ Hearing/Speech ☐ Physical Mobility
☐ Medical Conditions ☐ MR/DD ☐ Visual
☐ Allergies/Asthma ☐ Other (List in comments, please be specific):

Provider has had: _____

_____

_____

Environment:
☐ Field Trips ☐ Fenced Yard ☐ Pool/Waterfront ☐ Large Muscle Room
☐ No Pets ☐ Outdoor Pets Only ☐ Smoke Free ☐ Wheelchair Accessible
☐ Non-Smoking During Care Hours

Meals:
☐ Breakfast ☐ Morning Snack ☐ Lunch ☐ Afternoon Snack
☐ Dinner ☐ Special Diet ☐ Parent Provided
☐ USDA - If Yes, Name of USDA Food Sponsor: _____

Safety:
☐ CPR Current Within 2 Yrs. ☐ First Aid Training
☐ Communicable Disease ☐ Liability Insurance

Census Bureau Demographics:

Is this person Spanish/Hispanic/Latino?

☐ No, Not Spanish/Hispanic/Latino ☐ Yes, Puerto Rican ☐ Yes, Other (print)_____

☐ Yes, Mexican, Mexican Am., Chicano ☐ Yes, Cuban

What is this person's race?

☐ White ☐ Black/African Am./Negro ☐ American Indian or Alaska Native (print tribe)_____

☐ Asian Indian ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Vietnamese

☐ Other Asian (print race)_____ ☐ Guamanian or Chamorro ☐ Samoan

☐ Other Pacific Islander (print race)_____ ☐ Other Race (print race)_____

What is this person's ancestry or ethnic origin? _____(i.e. Italian, Jamaican, African Am, Cambodian, Haitian, Korean)

Does this person speak a language other than English at home? ☐ Yes ☐ No What language? _____

How well do the persons speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All

Update Completed by: _____

Date Completed: _____ **Best time to reach:** _____ **am/pm**

Please mail or fax the completed form to **Starting Point, 4600 Euclid Avenue, Suite 500, Cleveland, OH 44103 216-575-0102 (Fax)**. This form is also available online at **www.starting-point.org.** If you prefer to speak with someone directly, contact us at **216-575-0061 or 1-800-880-0971**. Thank you!

For Office Use Only

Staff Name: _____ ***Program ID No.*** _____

Date Received: _____ ***Date Entered:*** _____